MAJOR INJURY DETERMINATION FORM

This form must be completed, IF the facility is relying on the physician, designee*, or extender to determine whether a major injury has occurred. (NOTE: The facility may independently determine that a major injury has occurred and submit a self report.)

- The facility shall submit this Form to the Physician, Designee*, or Extender within 24 hours of when the injury occurred.
- A signed copy of this Form must be obtained by the facility from the physician, designee*, or extender within 72 hours of the injury.
- *If the physician, designee*, or extender refuses to complete the Form or is unavailable for completion and signature*, the DIA Director (or designee) must be notified of the injury within one business day.
- *If the physician, designee* or extender determines a major injury has occurred*, this signed Form shall be maintained by the facility in the resident's clinical record and the facility shall notify the department of the major injury,
- *If the physician, designee*, or extender determines the injury sustained is not a major injury*, this signed Form shall be maintained by the facility with the resident's clinical record.

TO BE COMPLETED BY THE FACILITY:

Resident name: _____

Date and time of the injury: _____

Description of injury: _____

_____

Circumstances of the incident causing the injury: _____

_____

Resident's previous functional ability: _____

_____

_____ / _____ Date: _____ Time: _____
Signature of Facility Representative Completing Form Print Name

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TO BE COMPLETED BY THE PHYSICIAN, DESIGNEE*, OR EXTENDER:
Patient's prognosis:

_____

_____

(CHECK ONE)

____ After reviewing the circumstances, injury, and prognosis of the patient, I believe the injury sustained is a major injury pursuant to 481 Iowa Administrative Code 50.7(1)(a)(3).

____ After reviewing the circumstances, injury and prognosis of the patient, I believe the injury sustained is NOT a major injury and, to the best of my knowledge, barring any complications, I believe the patient will return to his/her previous functional status.

I, _____ (please print name), the attending physician, designee* of the physician, or physician extender, of the above named patient, state that I have read the foregoing Determination Form, know the content thereof, and have made the determination of whether the patient's injury should be designated as a major injury based on the disclosure of the above information available on this date.

_____ Date: _____ Time: _____
Signature of Physician, Designee* of Physician, or Physician Extender

*Designee means another physician or physician extender in lieu of the attending physician.